



UNITED STATES MARINE CORPS  
MARINE CORPS BASE  
CAMP LEJEUNE, NORTH CAROLINA 28542-5001

BO P1754.2A Ch 1  
HSVC  
20 JAN 93

BASE ORDER P1754.2A Ch 1

DISTRIBUTION MADE

BY

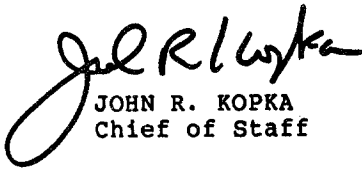
From: Commanding General  
To: Distribution List

0630 28 Jan 93 (TIME & DATE)

Subj: STANDING OPERATING PROCEDURES FOR CHILD DEVELOPMENT SERVICES  
(SHORT TITLE: SOP FOR CDS)

Encl: (1) New page inserts to BO P1754.2A

1. Purpose. To transmit a new page insert to the basic Order.
2. Action. Remove pages 1-7 and 1-8 of the basic Order and replace them with corresponding pages contained in the enclosure.
3. Summary of Change. To publish current fees and revise payment schedule.
4. Change Notation. Significant changes in the revised page are denoted by an asterisk.
5. Filing Instructions. File this Change transmittal immediately behind the signature page of the basic Order.
6. Certification. Reviewed and approved this date.

  
JOHN R. KOPKA  
Chief of Staff

DISTRIBUTION: A

RETURN TO CENTRAL FILES.  
NOB WITHIN 48 HOURS

# SOP FOR CDS

\*

## FULL-TIME ENROLLMENT PAYMENT SCHEDULE

1. The following payment schedule is effective 14 September 1992 at Camp Lejeune Child Development Centers.
2. Fees are payable in advance; monthly, on the 1st (for the 1st through the 15th) and on the 16th (for the 16th through the 30th/31st), or each Monday at the following rates:

<u>Total Annual Family Income</u>	<u>Fees Weekly/Payday</u>
\$ 0-11,000	\$37/\$80
11,001-27,000	\$47/\$102
27,001-40,000	\$59/\$128
40,001-55,000	\$69/\$150
55,001+	\$79/\$171

The payment plan elected upon enrolling will be the method of payment during the enrollment of your child.

3. Fees are based on a ten hour day. Care provided in excess of ten hours per day will be charged at the rate of \$1.50 per hour.
4. A \$5.00 per day late payment fee will be assessed for payment not received within 24 hours of due date. Additionally, failure to pay required fees within 24 hours of due date could result in disenrollment of your child.
5. A non-refundable \$25.00 annual registration fee per child is payable each September or upon enrollment.
6. Two weeks notification is required for disenrollment or semi-monthly payment will be charged.
7. If your child is enrolled during the pay period, the charge will be the pro-rated weekly/semi-monthly rate for the days left in the week/pay period. The same method will be used when disenrolling your child.
8. To remain enrolled, payment must be made even when your child is absent due to illness, vacation, etc.
9. The child development center has established hours of operation. Children remaining in the center after closing will be charged a \$6.00 late fee per child for the first half hour, or any portion thereof, and an additional \$3.00 for each 15 minutes thereafter. We ask that all children be picked up by the established closing time. Flagrant abusers of this policy will be warned and an additional late fee could be charged.

\*\*\*\*\*  
I acknowledge that I have read the above payment schedule and agree to its terms as indicated by my signature below.

PRINTED NAME OF PATRON \_\_\_\_\_

SIGNATURE OF PATRON \_\_\_\_\_ DATE \_\_\_\_\_

CDS-2

Figure 1-1.--Full-Time Enrollment Payment Policy

## CHILD'S MEDICAL ENROLLMENT FORM

AUTHORITY: Title 10, United States Code, Section 3012  
 PRINCIPAL PURPOSE: Information is used to contact parent/guardian in the event the child becomes ill or injured and to provide necessary background information on the child.  
 ROUTINE USES: No information is disclosed outside DoD.  
 DISCLOSURE: Disclosure of required information is voluntary; however, if the information is not provided, admittance of the child may be denied.

Name of Child \_\_\_\_\_  
 (Last, First, Middle)  
 Sex \_\_\_\_\_ Home Address \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
 Sponsor's Name \_\_\_\_\_  
 (Last, First, Middle)  
 SSN \_\_\_\_\_ Work Address \_\_\_\_\_  
 Rank/Rate (If Military) \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
 Other Parent's Name \_\_\_\_\_  
 (Last, First, Middle)  
 SSN \_\_\_\_\_ Work Address \_\_\_\_\_  
 Rank/Rate (If Military) \_\_\_\_\_ Work Phone Number \_\_\_\_\_

## IMMUNIZATION RECORD

	DATE	DATE	DATE	DATE	DATE	DATE
POLIO (ORAL)						
DPT						
MMR						
Others						

NOTE: Certification and transcription of immunization must be made from official documents signed by medical department personnel. Verbal transcription is NOT acceptable. If religious beliefs preclude immunization, a signed statement by the sponsor must be attached to this form. Objections based on specific or non-religious beliefs are NOT acceptable.

My child has had or has the following illness or injury (i.e., asthma, epilepsy, broken arm, measles, operation, etc.):

Illness/Injury \_\_\_\_\_ Date \_\_\_\_\_ Allergies \_\_\_\_\_  
 Illness/Injury \_\_\_\_\_ Date \_\_\_\_\_ Sensitivities \_\_\_\_\_

NOTE: No medication may be dispensed by Child Development Center personnel.

I hereby certify that to the best of my knowledge, my child is free of any obvious illness and is in good health. In the event that I am not available or should my child become ill/injured or show signs of illness, I hereby authorize the following persons to pick up my child in my absence:

	NAME	ADDRESS	PHONE
(1)	_____	_____	_____
(2)	_____	_____	_____

\_\_\_\_\_  
 Signature and Date

I hereby authorize the Naval Hospital, Camp Lejeune, North Carolina, to administer the necessary medical treatment required to maintain life to my above mentioned child in the event of serious illness or injury in my absence.

\_\_\_\_\_  
 Signature and Date